Authorization to Treat Child(ren) In Absence of Parent/Guardian

Physician Practices of AdventHealth Ottawa

I hereby give my permission to the Medical Staff of AdventHealth Ottawa Physician Practices to treat my child(ren) in my absence.

Child(ren):

Name: _____ Birthdate: _____
Name: _____ Birthdate: _____
Name: _____ Birthdate: _____
Name: _____ Birthdate: _____
Name: _____ Birthdate: _____

The following person(s) has the authority to seek treatment at AdventHealth Ottawa Physician Practices for my child(ren):

_____

I am unable to bring my child(ren) in during this time period for the following reason(s):

_____

I understand this authorization is valid for one year unless dates are specified here:

From: _____ To: _____

Further, I have read and agree to adhere to the Financial Policy of AdventHealth Ottawa Physician Practices in regards to my financial responsibility for this visit(s). I understand that I am the guarantor for my child(ren) healthcare expenses.

Date:_____ Signature: _____

_____
Relationship to child(ren)
(Parent or Legal Guardian)